

**Corrina Duvall, Psy.D  
Licensed Psychologist  
Certified School Psychologist**

**Patient Registration Form**

<b>Name:</b>	<b>Date of Birth:</b>	<b>Grade:</b>	<b>Date:</b>
<b>Child lives with (circle):</b> <b>Mother (name):</b> _____ <b>(please circle below)</b> <b>Father (name):</b> _____ <b>Mother and father at same location</b> <b>Other:</b> <b>Mother and father at separate location</b>			
<b>Mother's Phone (home):</b>		<b>Mother's Phone (work):</b>	
<b>Mother's Cell Phone:</b>		<b>Mother's Email address:</b>	
<b>Mother's Address:</b>			
<b>Father's Phone (home):</b>		<b>Father's Phone (work):</b>	
<b>Father's Cell Phone:</b>		<b>Father's Email address:</b>	
<b>Father's Address</b>			
<b>Name of person to call in an emergency:</b>			<b>Relationship:</b>
<b>Street:</b>			<b>Suite/Apt. #:</b>
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>	
<b>Phone:</b>			
<b>Name of person completing this form (if not patient):</b>			
<b>Name of Primary Care Physician (PCP):</b>			<b>Date last seen:</b>
<b>PCP Office Address:</b>			<b>Suite/Apt. #:</b>
<b>City:</b>	<b>State:</b>	<b>ZIP code:</b>	
<b>Phone:</b>	<b>Fax:</b>		

# Credit/Debit Payment Agreement

**\* Payment by cash or check is due at the time of service.**

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

\_\_\_\_ I authorize Corrina C. Duvall PSYD to keep my signature on file and to charge my Visa, MasterCard, American Express or Discover listed below for fees due on the account of the patient named above, including:

- DEDUCTIBLES that were not paid at the time of service
- COINSURANCE that was not paid at the time of service
- COPAYMENTS that were not paid at the time of service
- NON-COVERED MEDICAL ENTITIES which are reviewed in the outpatient services contract
- OUT OF POCKET COSTS (e.g., late fees, insufficient funds checks and fees)
- LATE CANCELLATION/NO SHOW

The card(s) may be charged **automatically** after the original time and date of service if payment was not provided at the time of service. I understand that only cash and check are accepted at the time of service. **Note that balances not paid at the time of service will be charged a \$10.00 late fee.** Receipts will be sent upon payment processing to the email address indicated below. I may continue to schedule appointments provided my credit card remains on file, is valid, and additional fees are not accrued.

\_\_\_\_\_  
Visa, MasterCard, American Express, Discover (circle one)  
**(I cannot charge HSA/HFA/Flex Spending cards)**

Card #: \_\_\_\_\_

Card Expiration Date: \_\_\_\_/20\_\_\_\_

CV (back of card): \_ \_ \_

Billing Zip Code: \_\_\_\_\_

I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying the above named patient charges in full at the time of service or I will make alternative arrangements for payment. I further understand that withdrawal of this authorization OR declination of my credit card upon payment processing will affect my ability to schedule appointments and may result in cancellation of future appointments. I must provide an email address to which receipts will be sent upon payment processing.

\_\_\_\_\_  
Cardholder Name

\_\_\_\_\_  
Cardholder's Relationship to Patient

\_\_\_\_\_  
Cardholder Billing Address

\_\_\_\_\_  
City, State Zip

\_\_\_\_\_  
Signature of Cardholder

\_\_\_\_\_  
Date

**Email address (required):** \_\_\_\_\_

I have read and agree to the terms of the payment option(s) I have chosen above and acknowledge that I will be provided with a signed copy of this election form.

\_\_\_\_\_  
**Signature of Patient**  
**(Parent/Guardian if Patient is under 18 yrs old)**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**

**Staff Initials and Date:** \_\_\_\_\_ **Copy Provided: YES/NO**

**Corrina Duvall, Psy. D**

139 Vly Road, Albany, NY 12205 \* (518) 608-4271 \* Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

The purpose of this form is to give me permission to contact others regarding your child’s care. You must complete a separate form for each contact.

I, \_\_\_\_\_, authorize Corrina C. Duvall, Psy.D. to release and obtain the health information described below to:

Name of Primary Care Physician or medication prescriber:	
Contact Info (please include email, phone#, and fax #)	

This request and authorization applies to only the following protected health information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List each purpose or reason for the use or release of the protected health information: \_\_\_\_\_

\_\_\_\_\_

This authorization shall remain in full effect until the end of our treatment relationship or it will expire 5 years from today, whichever comes first.

I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to:

Corrina Duvall Psy.D, 139 Vly Road, Albany, NY 12205 Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

I understand that Corrina Duvall, Psy.D may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is related to the research project.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Patient’s signature (relationship if signed by parent / guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness’ signature

\_\_\_\_\_  
Date

**Corrina Duvall, Psy. D**

139 Vly Road, Albany, NY 12205 \* (518) 608-4271 \* Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

**AUTHORIZATION FOR RELEASE OF INFORMATION**

The purpose of this form is to give me permission to contact others regarding your child’s care. You must complete a separate form for each contact.

I, \_\_\_\_\_, authorize Corrina C. Duvall, Psy.D. to release and obtain the health information described below to:

Name of School Staff Member:	
Contact Info (please include email, phone#, and fax #)	

This request and authorization applies to only the following protected health information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List each purpose or reason for the use or release of the protected health information: \_\_\_\_\_

\_\_\_\_\_

This authorization shall remain in full effect until the end of our treatment relationship or it will expire 5 years from today, whichever comes first.

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\_\_\_\_\_  
Patient’s signature (relationship if signed by parent / guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness’ signature

\_\_\_\_\_  
Date

## Consent for Child and Adolescent Therapy

**MY APPROACH:** Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child’s confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Outpatient Services Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise. One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child’s therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision; however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

**SHARING INFORMATION:** Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child’s treatment records. It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. I will tell you if your child does not attend sessions. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child.

**LEGAL ISSUES:** I require that you will treat anything that is said in session with me as confidential. This means that neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, should I be involved in legal proceedings, it is agreed that my services will be paid for by the responsible party at my then current rates per hour of time.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

## Corrina Duvall, Psy. D

139 Vly Road, Albany, NY 12205 \* (518) 608-4271 \* Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

# Outpatient Services Contract

Welcome! This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

**MEETINGS:** I normally conduct an initial diagnostic assessment, via clinical interview, that lasts 1-2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your goals.

**CANCELLATION POLICY:** Most days, there is a waiting list of patients who are eager to set up an appointment as soon as possible. As such, it is important to keep your appointment for the time it was scheduled.

- Appointments that are cancelled more than 24 hours in advance will *not* be charged a cancellation fee.
- Appointments that are cancelled less than 24 hours in advance are subject to a \$50.00 late cancellation fee.
- If you do not show to your scheduled appointment without a prior phone call, a \$90.00 fee is charged.
- If your medical insurance does not allow me to charge you for cancellation fees, you will no longer be permitted to make appointments with me after two late cancellations or missed appointments.

### PROFESSIONAL FEES:

- ***Out-of network:*** If I do not accept your insurance, I can still provide my services as an out of network provider. In that case, my fee for 45-minute psychotherapy sessions is \$150.00; my fee per hour of psychological testing and consultation is \$170.00. This includes hours for scoring, interpretation of data, and report writing, which take place outside of sessions.
- ***Insurance:*** Co-pay/deductibles/co-insurance is required at the time of service for each psychotherapy and psychological testing session. Invoices will be sent home for copays that are incurred for scoring and interpretation which take place outside of sessions. I accept cash or check on the day of service. Please make checks payable to Corrina Duvall. Fees not paid at the time of service will be subject to a \$10.00 late payment charge. Both the fees and the late payment charge will be charged automatically to your credit/debit card if payment is not received at time of service. See the “Credit/Debit Payment Agreement” form for more detailed information.
- ***Other:*** I offer a number of services that may not be deemed “Medically necessary” (e.g., school observations) by your insurance company. These services are billed at my private pay rate. You may choose to pay for these services out of pocket once we have agreed upon what the services entail and cost, and you have signed an agreement for me to bill you for these non-covered services. Please see the “Billing Agreement for Non-Covered Services” form for more information. Additionally, if you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party, at my then current rates per hour of time. I do not, however, become involved in child custody matters.

**BILLING AND PAYMENTS:** You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Should your insurance coverage lapse, and an appointment is held without my knowledge of the lapse, you will be

responsible for covering the out of pocket cost of the session. This applies to Medicaid/Managed Medicaid clients as well. Please refer to the Credit/Debit Card Payment Agreement form for detailed information about how outstanding balances are charged. This also applies to cancellation and no-show fees.

**INSURANCE REIMBURSEMENT:** In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental (behavioral) health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental (behavioral) health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental (behavioral) health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. It may be necessary to seek approval for more therapy after a certain number of sessions. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it. I will provide you with a copy of any report I submit, if you request it. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

**OFFICE HOURS:** Psychology Wellness Practice, PLLC. is open Monday through Thursday. The phone line for reception is open from 9AM-5PM on these days. Appointments are sometimes held outside of these hours. On some occasions we may need to close for *inclement weather*, and may vary by provider. In this case, I will open up new appointment slots in order to reschedule your appointment in a timely manner.

**CONTACTING ME:** I am often not immediately available by telephone. When I am unavailable, the office telephone is answered by voice mail or by one of our secretaries. I am in the office on Tuesdays, Wednesdays, and Thursdays, and will make every effort to return your call on those days. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist/psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**ELECTRONIC COMMUNICATIONS:** Various types of electronic communications are common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

- ***Email Communications:*** I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

- **Text Messaging:** Since text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.
- **Social Media:** I do not communicate with, or contact, any of my patients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with patients online have a high potential to compromise the professional relationship.

**UNPLANNED ENCOUNTERS:** To protect client confidentiality, if I happen to see you in public at any time I will not initiate any contact with you. If you choose to greet me I will reciprocate, but I will not communicate further unless you request it.

**CONFIDENTIALITY:** In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient’s treatment. For example

- If I believe that a child is being abused, I must file a report with the appropriate state agency.
- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- Insurance: See insurance reimbursement section.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

**RECORDING SESSIONS:** Psychotherapy is a private activity, where sensitive and difficult topics are discussed. As a result, if you want to record all or parts of a session, my policy is that we discuss it first and decide if it is appropriate. If you violate this policy, I will no longer be willing to work with you as it is detrimental to the therapeutic relationship and destroys the “safe space” our sessions are meant to provide as a means of confidential communication.

**Statement of Release by Parent/Guardian to Insurance Company:** I request that payment of authorized insurance benefits be made on my child’s behalf to Corrina C. Duvall PSYD. for services furnished to me by this practitioner. I authorize Corrina C. Duvall PSYD to release medical and psychological information about my child to the applicable insurance company should any information be needed to determine these benefits. By signing this consent, I acknowledge that I have read it and the Notice of Privacy Practices, or that they have been read to me, that I am at least 18 years old (or, if under 18, married or the parent of a child), that I understand the above agreement, and that I am signing this consent voluntarily.

**Office does not discriminate (based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability including conditions arising out of acts of domestic violence , disability, genetic information, or source of payment) in the delivery of health care services and accept for treatment any member in need of health care services they provide. In the event of a health emergency I will obtain assistance by calling 911.**

\_\_\_\_\_  
Patient/Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date



## Informed Consent Addendum for On-line/Tele-therapy

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

I understand that therapy conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3<sup>rd</sup> party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I agree to call my therapist back at: (518) 608-4271.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Telehealth Link: <https://doxy.me/drduvall>

### ***Consent to Treatment***

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize **Dr. Corrina Duvall** to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through **Dr. Corrina Duvall** at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

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Patient/Client Signature Date

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Parent, Guardian or Legal Representative Signature Date  
(if minor or needed otherwise)

# Corrina Duvall, Psy. D

Licensed Psychologist \* Certified School Psychologist

139 Vly Road, Albany, NY 12205 \* (518) 608-4271 \* Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

## Outpatient Services Agreement for Collaterals

**INTRODUCTION:** I want to thank you for accepting the invitation to assist in my patient's psychotherapeutic treatment. Your participation is important, and is sometimes essential to the success of the treatment. This document is to inform you about the risks, rights and responsibilities of your participation as a collateral participant.

**WHO IS A COLLATERAL?** A collateral is usually a spouse, family member, or friend, who participates in therapy to assist the identified patient. The collateral is not considered to be a patient and is not the subject of the treatment. Psychologists have certain legal and ethical responsibilities to patients, and the privacy of the relationship is given legal protection. My primary responsibility is to my patient and I must place their interests first. You also have less privacy protection.

**THE ROLE OF COLLATERALS IN THERAPY:** The role of a collateral will vary greatly. For example, a collateral might attend only one session, either alone or with the patient, to provide information to the therapist and never attend another session. In another case, a collateral might attend all of the patient's therapy sessions and his/her relationship with the patient may be a focus of the treatment. We will discuss your specific role in the treatment at our first meeting and other appropriate times.

**BENEFITS AND RISKS:** Psychotherapy often engenders intense emotional experiences, and your participation may engender strong anxiety or emotional distress. It may also expose or create tension in your relationship with the patient. While your participation can result in better understanding of the patient or an improved relationship, or may even help in your own growth and development, there is no guarantee that this will be the case. Psychotherapy is a positive experience for many, but it is not helpful to all people.

**MEDICAL RECORDS:** No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified patient's chart. The patient has a right to access the chart and the material contained therein. It is sometimes possible to maintain the privacy of our communications. If that is your wish, we should discuss it before any information is communicated. You have no right to access that chart without the written consent of the identified patient. You will not carry a diagnosis, and there is no individualized treatment plan for you.

**FEES:** As a collateral, you are not responsible for paying for my professional services unless you are financially responsible for the patient.

**CONFIDENTIALITY:** The confidentiality of information in the patient's chart, including the information that you provide me, is protected by both federal and state law. It can only be released if the identified patient specifically authorizes me to do so. There are some exceptions to this general rule:

- If I suspect you are abusing or neglecting a child or a vulnerable adult, I am required to file a report with the appropriate agency.
- If I believe that you are a danger to yourself (suicidal) I will take actions to protect your life even if I must reveal your identity to do so.
- If you threaten serious bodily harm to another I will take necessary actions to protect that person even if I must reveal your identity to do so.
- If insurance is used to pay for the treatment, the patient's insurance company may require me to submit information about the treatment for claims processing purposes or for utilization review.

You are expected to maintain the confidentiality of the identified patient (your spouse, friend, or child) in your role as a collateral.

**DO COLLATERALS EVER BECOME A FORMAL PATIENT?** Collaterals may discuss their own problems in therapy, especially problems that interact with issues of the identified patient. The therapist may recommend formal therapy for a collateral. These are some examples of when this might occur.

- It becomes evident that a collateral is in need of mental health services. In this circumstance the collateral needs to have a clinician, diagnosis, and chart records kept.
- Parents, being seen as collaterals as their child is being treated, need couples therapy to improve their relationship so they can function effectively as parents.

Most often, but not always, your clinician will refer you to another clinician for treatment in these situations. There are two reasons the referral may be necessary:

- Seeing two members of the same family, or close friends, may result in a dual role, and potentially cloud the clinician's judgement. Making a referral helps prevent this from happening.
- The clinician must keep a focus on the original primary task of treatment for the identified patient. For example, if the clinician started treating a child's behavioral problem, then takes on couples' therapy with mom and dad to address their relationship problems, the original focus of therapy with the child may be lost. A referral helps the clinician to stay focused.

One exception to these guidelines is when a family therapy approach can be effectively and ethically used to treat all members of the family, or each of the couple.

**RELEASE OF INFORMATION:** The identified patient is not required to sign an authorization to release information to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the patient is adequate. This provides some assurance that full consent has been given to the clinician for the patient's confidential information to be discussed with the collateral in therapy. The Release of Information Form is, however, helpful to the clinician on those occasions when receiving a telephone call from a collateral or when the clinician calls a collateral for one reason or another. In most instances the clinician cannot take a call from a collateral without a Release of Information form.

**PARENTS AS COLLATERALS:** Clinicians specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often recommended. Parents in particular have more rights and responsibilities in their role as a collateral than in other treatment situations where the identified patient is not a minor.

- In treatment involving children and their parents, access to information is an important and sometimes contentious topic. Particularly for older children, trust and privacy are crucial to treatment success. But parents also need to know certain information about the treatment. For this reason, we need to discuss and agree about what information will be shared and what information will remain private. In general, I believe that parents should be informed about the goals of treatment and how the treatment is going and whether the child comes to his/her appointments. I will always inform you if I think that your child is in danger or if he/she is endangering others. One of our first tasks is to discuss and agree on our shared definition of dangerousness so we are all clear about what will be disclosed.
- If you are participating in therapy with your child, you should expect the clinician to request that you examine your own attitudes and behaviors to determine if you can make positive changes that will be of benefit to your child.

**SUMMARY:** If you have questions about therapy, my procedures, or your role in this process, please discuss them with me. Remember that the best way to assure quality and ethical treatment is to keep communication open and direct with your clinician. By signing below you indicate that you have read and understood this document.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Consent for Psychological Testing

(Signing this form will give me permission to administer a rating scale that I typically give at the end of the first session. I understand that you are not pursuing a complete evaluation.)

- I, \_\_\_\_\_, give my consent to Dr. Corrina Duvall, to conduct psychological/psychoeducational testing and/or observations of me/my child, \_\_\_\_\_.
- I understand that I may withdraw this consent at any time during the assessment or treatment process, but that I will still be financially obligated to pay for the services rendered.
- I understand that if this evaluation is being reimbursed by a third party (e.g., school district, agency) and I withdraw my consent to share the evaluation findings I am then financially obligated to pay for the entire assessment.
- I also understand that the assessment includes face-to-face time, as well as time needed for scoring, interpretation, and report writing. I understand that I will be responsible for copay or deductible on each billable hour (subject to vary depending on the time approved by your insurance company). I understand that I will be responsible for the full amount, if I choose to privately pay. I understand that I will need to pay my balance in full prior to receiving the psychological report, which will be discussed in a feedback session.
- My consent for testing and/or treatment will be terminated when revoked in writing.
- Insurance and school district payment sources need to be secured prior to the evaluation or consultation. Written confirmation of such approval is needed. Reimbursement for services rendered will be the responsibility of the patient and/or parent if this has not occurred.
- I agree to pay for this visit should there be denial of coverage by other sources.
- If I have any questions regarding the above, I will address them with Dr. Corrina Duvall at my first visit.

**Private Pay Clients Only:** It is requested that payment for services occur at the time of the office visit.

\_\_\_\_\_  
Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Child/Adolescent Therapy Questionnaire

<b>FAMILY DATA</b>		
<b>Child's Name:</b>	<b>Date of Birth:</b>	<b>Today's Date:</b>
<b>Person completing this form:</b>		<b>Relationship to Child:</b>
<b>Mother's Name:</b>		<b>Occupation:</b>
<b>Father's Name:</b>		<b>Occupation:</b>
<b>Marital Status of Parents:</b>		<b>What is the current custody arrangement?</b>
<b>If parents are separated or divorced, how old was your child when separation occurred?</b>		
<b>Is your child adopted?</b>	Please describe any specific information about the adoption (e.g., significant events prior to adoption, etc.)	

List all people living in the household:

Name	Relationship to child	Age

If any brothers or sisters are living outside the home, list their names and ages: \_\_\_\_\_

Primary language spoken in the home: \_\_\_\_\_

**Below, please specify family members (e.g., child's sister, maternal aunt, paternal grandmother) that have experienced any of the following:**

	MOTHER	FATHER	SIBLING	GRAND-PARENT	AUNT/UNCLE
<b>Depression</b>					
<b>Anxiety</b>					
<b>Attentional Difficulties</b>					
<b>Hyperactivity</b>					
<b>Emotional/Behavior Problems</b>					
<b>Autism</b>					
<b>Other Mental Health conditions (e.g., Schizophrenia, Bipolar Disorder)</b>					

# PRESENTING PROBLEM

**1. What prompted you to make an appointment?**

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**2. Please list your child’s current diagnoses, if any.**

A. Diagnosis \_\_\_\_\_ Date Diagnosed \_\_\_\_\_

Provider who made Diagnosis \_\_\_\_\_

B. Diagnosis \_\_\_\_\_ Date Diagnosed \_\_\_\_\_

Provider who made Diagnosis \_\_\_\_\_

C. Diagnosis \_\_\_\_\_ Date Diagnosed \_\_\_\_\_

Provider who made Diagnosis \_\_\_\_\_

\*Please consider signing a release of information form for the above practitioners.

**3. What other evaluations has your child had?** Please include Occupational Therapy (OT), Physical Therapy (PT), Speech and Language, Psychoeducational, Neurological, Autism, ADHD, Central Auditory Processing (CAPD) and/or any other social, educational, or psychological evaluation. Please use the chart below to list the provider and type of evaluation. It is most helpful if you include a copy of these evaluation reports when you come in for your initial appointment.

Provider	Evaluated for:	Date:	Outcome/Diagnosis

*4. Please list all schools that your child has attended, including preschool and nursery school experiences.*

Name of School	Location/District	Dates Attended/Grades Completed

5. Has your child ever repeated a grade?    Yes    No    If yes, what grade and why? \_\_\_\_\_

6. Does your child have an Individualized Education Plan (IEP) or 504 Accommodation plan? If so, please provide us with a copy of the plan.    Y / N

## Corrina Duvall, Psy. D

950 New Loudon Rd., Suite 101, Latham, NY 12110 \* (518) 608-4271 \* Email: [Dr.CorrinaDuvall@gmail.com](mailto:Dr.CorrinaDuvall@gmail.com)

### PLEASE CHECK ALL THAT ARE A PROBLEM FOR YOUR CHILD

__ Seems depressed	__ Communication Difficulties
__ Suicidal thoughts or actions	__ Low Self-Esteem
__ Anxious/Worried	__ Issues related to custody/visitation
__ Moody/Sad	__ Victim of sexual abuse
__ Panic Attacks or Intense Fears	__ Domestic violence (verbal, physical, threats)
__ Anger Problems, quick temper	__ Conduct Problems, in trouble with the law
__ Physically fighting with others	__ Eating Disorder Symptoms
__ Outbursts or Explosive Behavior	__ Family Problems
__ Alcohol/other drug abuse	__ Parent Drug/Alcohol abuse
__ Predicts the worst	__ Academic difficulties in school
__ School Problems: Check all that apply __ Not listening to teacher      __ School Avoidance __ Incomplete Homework      __ Fighting at school __ Suspensions or Expulsion      __ Victim of bullying __ Lack of work completion at school __ Bullies Others	__ Family Problems: Check all that apply __ Conflicts with (circle): mother    father    sibling    Step-parent __ Parent marital problems      __ Domestic violence __ Running away from home      __ Verbal Aggression __ Disobedient/Oppositional      __ Physical Aggression
__ Death of a loved one	__ Toileting Accidents
__ Major losses/difficult changes	__ Fire setting
__ Frequent stealing, lying, cheating	__ Shy, clingy, wants to be with parents
__ Very active, possibly hyperactive	__ Sleep Difficulties
__ Problems with Friends	__ Doesn't think before acting
__ Does not appear sorry for actions	__ Does cruel or strange things
__ Bangs head	__ Easily frustrated
__ Cuts or burns self	__ Inflexible
__ Difficulty focusing	__ Holds grudges
__ Over-focused on certain tasks	__ Fails to initiate or respond to social interaction
__ Distracted	__ Memory Problems
__ Disorganized	__ Refusal to deviate from routines
__ Temper problems	__ Low-level frequent sadness
__ Has a narrow range of interests	__ Repetitive movements
__ Intense focus or preoccupation with certain Topics	__ Sensitive to light, sound or touch
__ Unusual body language	__ Lack of eye contact
__ Difficulty shifting attention	__ Becomes distressed when things do not go as Expected
__ Tense	__ Lack of Facial Expressions

What are your child's strengths?: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEDICAL/DEVELOPMENTAL HISTORY

1. Child was (circle): Full-term / Premature at birth.
2. Were there any prenatal difficulties? Yes No If yes, please describe \_\_\_\_\_
3. Child's weight at birth? \_\_\_\_\_ lbs. \_\_\_\_\_ oz. 3.
4. Were forceps used during delivery (circle)? Yes No
5. Was a Caesarean section performed (circle)? Yes No If yes, for what reason? \_\_\_\_\_
6. Were there complications during birth? \_\_\_\_\_
7. Child's health at birth? \_\_\_\_\_
8. Were there any birth defects or complications (circle)? Yes No If yes, please describe: \_\_\_\_\_
9. Were there any special problems in the growth and development of the child during the first few years?  
Yes No If yes, please describe: \_\_\_\_\_

**10. Please check any of the following that your child has experienced:**

<b>Hearing Difficulty</b>		<b>Recurrent Ear Infections</b>	
<b>Vision Difficulty</b>		Vision Therapy	
<b>Strep Throat</b>		Change in Behavior after strep throat	
<b>Concussion</b>		Testing for Seizure Disorder	Result:
<b>Traumatic Brain Injury (TBI)</b>		Staring Spells	
<b>Serious accident/hospitalization</b>		Chiropractic Care	Treated for:
<b>Tick Bite</b>		Testing for Lyme Disease	Result:
<b>Environmental Allergies</b>		Evaluated for PANDAS	Result:
<b>Food Allergies</b>		Evaluated for PANS	Result:
<b>Tics</b>		Stuttering (dysfluent speech)	

11. Please further explain any of the above:

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**12. Please list any medications your child takes:**

Name of Medication	Dose	Purpose of medication	Prescribed by:

**13. Has your child previously been on ineffective psychotropic medications? Please list and explain:**

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Corrina Duvall, Psy.D  
Licensed Psychologist  
Certified School Psychologist

### **Notice of Privacy Practices**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**If you have any questions about this notice please contact the Privacy Contact who is:  
Corrina Duvall, Psy.D**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

#### **1. Uses and Disclosures of Protected Health Information**

##### **Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

##### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization,

unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

### **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

## **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.